WASHINGTON COUNTY

NEW HIRE ENROLLMENT GUIDE

2021

WASHINGTON COUNTY
EST 1836
WISCONSIN

DISCOVER. CONNECT. PROSPER.

Welcome

Washington County offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This Employee Benefits Guide contains information about each of the benefit programs available to you and changes you can expect for the upcoming year.

NOTE: All benefit elections for will be made through Washington County's Employee Self Service (ESS) system. Please refer to page 4 for instructions on how to make benefit elections for 2021.

Elections made during your initial enrollment with be effective the 1st of the month following 30 days of employment.

Read through this information carefully. If you have questions about your benefits or the information provided in this booklet, please contact your Human Resources Department at 262-335-4633.

Check out our Benefit App for detailed information for all the benefit programs:
https://washingtoncounty.mybenefitsapp.com/

The information in this benefit overview guide is intended for informational use only. It does not include all of the benefit provisions, limitations, and qualifications. If this information conflicts with any insurance or administrator contracts or certificates in any way, the official plan documents will prevail. For specific information or complete details, please refer to your Summary Plan Description.

Table of Contents and Contact List

Benefit Eligibility & Enrollment

Benefit Eligibility by FTE:

Medical Benefits: .75 – 1.0 FTE employees

Dental: .5 – 1.0 FTE employees

Life Benefits – See the Life Benefit page for eligibility requirements.

Definition of Employee Status:

- 1.0 FTE employees work 40 hours or more per week
- .75 - .95 FTE employees work 30 - 39 hours per week meet the requirements for medical benefits per the Affordable Care Act Medical Eligibility Guidelines
- .5 - .7 FTE employees work 20 - 29 hours per week

The following family members are eligible for medical and dental coverage: your legal spouse, your child(ren) up to age 26 regardless of marital, student, or employment status, your children of any age who are incapable of supporting themselves due to a mental or physical disability and who are totally dependent on you.

Changes during the year

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence, commencement or termination of adoption proceedings, change in employment status or change in coverage under another employer-sponsored plan.

How to enroll

Enrollment for benefits is be conducted online through Employee Self Service (ESS). The website can be accessed from work or from home: https://mywc.washcowisco.gov/ess.

Instructions: Log in to ESS (username is your 5 digit employee ID number and the password is the last 4 digits of your social security number). Click on the following navigation: Self Service, Benefits, Benefits Enrollment. Click through each benefit option to either elect or decline coverage. After all elections have been made, click Continue to review your elections, then click Submit Choices at the bottom of the page.

Please print or save the Confirmation page for your records. After your initial enrollment closes, you will not be able to make changes until the next open enrollment period unless you have a qualified change in status.

Employee Health Center

Washington County is committed to you and your family's needs when it comes healthcare. We have installed an Employee Health Center to provide a convenient and cost effective place for you to help with some of your common healthcare needs.

Services exclusively for you

- Physicals (including school and sports)
- Adult and pediatric immunizations (ages 2 and older)
- Treatment for illnesses and injuries
- Minor procedures (such as sutures or removals of skin tags, moles and warts)
- Personalized health and wellness coaching
- Management of chronic conditions
- Lab services (including orders from outside providers)
- Selected medications (prescribed at the Employee Health Center)

Cost

- FREE preventative visits
- $25 office visits
- $10 lab visits
- $5 for a 30-day supply of selected medications

Clinic Location

Washington County Government Center
432 E. Washington St. Suite 1115
West Bend, WI 53095

Hours

Monday, Wednesday, Friday
7:00 a.m. – 4:00 p.m.
Tuesday, Thursday
9:00 a.m. – 6:00 p.m.

To schedule an appointment:

- Visit **myquadmed.com/ehc**
- Call 844-827-1814

WASHINGTON COUNTY

City of West Bend

EMPLOYEE HEALTH CENTER

MANAGED BY QUADMED®

Medical Benefits

Washington County's Medical and Rx plan offers great flexibility in managing care for you and your family. The medical plan is administered by UMR, a United Healthcare Company and the prescription drug plan is administered by OptumRx. These plans are considered a Qualified High Deductible Plan that can be used in conjunction with a Health Savings Account (HSA).

Coverage: Under this plan, you have comprehensive coverage that gives you access to a number of providers within a network when you are home and even if you are travelling out of the area. You can even choose a specialist anytime without a referral. Plus, by choosing to visit these network physicians and facilities, you will receive a higher level of benefits which can save you out-of-pocket costs.

Medical Plan Benefit Summary			
		In-Network	**Out-of-Network**
Deductible (per calendar year)	Individual	$1,500	$3,000
	Family	$4,000	$8,000
Coinsurance		100%	80%
Out-of-Pocket Maximum (per calendar year)	Individual	$1,500	$5,000
	Family	$4,000	$12,000
Preventive Care		100% covered, no deductible	80% after the Deductible
Non-Preventive Care		100% after the Deductible	80% after the Deductible
Prescription Copay Out-of-Pocket (AFTER the deductible is met)			
		Retail: 30 day supply	**Mail Order: 90 day supply**
Generic Drugs		$10	$20
Preferred Brand		$25	$50
Non-Preferred Brand		$40	$80
Diabetic Supplies		$20	$40
Insulin		$0	$0

Full-Time (1.0 FTE) Enrolled After 2/28/2016

	Monthly Cost	Per Paycheck Cost
Individual	$93.68	$46.84
Family	$233.44	$116.72

ACA (0.75 – 0.95 FTE) Enrolled After 2/28/2016

	Monthly Cost	Per Paycheck Cost
Individual	$281.08	$131.17
Family	$700.34	$350.17

For a full summary of your plans refer to the Summary Plan Description Document found on PACKET or contact Human Resources.

TELADOC

24/7 doctor visits via phone or mobile app

TELADOC

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. It's an affordable option for quality medical care.

- Talk to a doctor anytime, anywhere you happen to be
- Receive quality care via phone, video or mobile app
- Prompt treatment, median call back, in 10 minutes
- A network of doctors that can treat every member of the family
- Prescriptions sent to pharmacy of choice if medically necessary
- Teladoc is less expensive than the ER or urgent care

Talk to a doctor anytime!
visit **Teladoc.com**
or call
1-800-Teladoc

Google play

Get the care you need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

UMR
A UnitedHealthcare Company

Health Savings Account (HSA)

BMO Bank of Montreal

Establishing a HSA allows you to contribute pre-tax dollars and withdraw funds tax-free if they are used for eligible medical expenses. You own the account, but both you and Washington County can contribute funds.

Examples of eligible medical expenses include:

- Most medical, dental and vision care that applies to your deductible, coinsurance or copays
- Prescription drugs

2021 Health Savings Account (HSA) Limits (Employer + Employee):

- Employee Only – $**3,600**
- Employee plus Spouse/Dependents – $**7,200**
- Employees Age 55 or Older – can contribute an additional $1,000

High Level Guidelines of HSA plans are as follow:

- You must be enrolled in a qualified high deductible health plan (HDHP) in order to establish ***and*** contribute to an HSA.
- You **may not be** enrolled in Medicare.
- You must not be claimed as a dependent for tax purposes.
- If you use HSA funds for expenses beyond what the IRS defines as qualified, you will be subject to income tax on the distribution and an additional penalty of 20%.

HSA and Age 65

Effects of Medicare: At age 65, you become eligible for Medicare and may be automatically enrolled. Enrolling in Medicare ends your HSA eligibility in one of two ways:

- If Medicare is your only health insurance, you are no longer eligible to contribute to an HSA because Medicare is not a HDHP.
- If you have Medicare as a secondary coverage in addition to an employer-sponsored HDHP, you will lose HSA eligibility because you have "other coverage."

When you turn 65 and begin Medicare coverage, you lose HSA eligibility on the first day of that month. For example, if your birthday is April 19, you are no longer eligible to contribute to an HSA as of April 1. For the months prior to your birthday, you are still eligible for an HSA (assuming you have an HDHP). Your maximum contribution is determined by adjusting the HSA maximum in accordance with how many months of the year that you were eligible. For example, if you turn 65 in April, you were eligible for the first three months of the year. You can then contribute 3/12 of the HSA annual contribution maximum.

If you reach age 65 and have an employer-sponsored HDHP, you must avoid Medicare enrollment if you would like to remain eligible for your HSA. In addition, if you don't enroll in Medicare Part A when you're first eligible, you may have to pay a penalty in the form of a higher Medicare premium for a period of time, once you do enroll in Medicare.

Dental Benefits

Washington County offers the Delta Dental Plan; this plan provides benefits for most types of basic and major dental care after you meet the deductible.

The summary below does not cover all plan details. Further information can be found in the summary plan description or dental benefit handbook. That document provides a thorough explanation of your dental plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

Delta Dental Services	Benefits
Individual Deductible	$50
Family Deductible	$150
Annual Maximum	$1,000
Copay	None
Preventive Services **Exams, cleanings, x-rays**	100%, no deductible
Basic Services **Fillings, simple extractions**	100% after deductible
Major Services **Oral surgery, root canal, crowns**	50% after deductible
Orthodontics (Up to Lifetime Maximum) **For dependent children under age 19**	50% after deductible
Orthodontics Lifetime Maximum	$1,500 per child

Employee Payroll Contributions	Total Monthly Employee Cost	Per Paycheck Employee Cost
Employee	$35.28	$17.64
Employee + Spouse	$84.90	$42.45
Employee + Child(ren)	$82.76	$41.38
Family	$129.78	$64.89

Flexible Spending Account

Discovery Benefits

If you have out-of-pocket health and/or dependent care expenses in 2021, it may benefit you to take advantage of the Flexible Spending Account (FSA) plan. Flexible Spending Accounts help you plan, budget and save on the cost of what you pay for health and dependent day care.

Option 1: Health Care Flexible Spending Account (HCFSA) – *if not enrolled in High Deductible Health Plan*

A health care FSA allows you to set aside pre-tax money through payroll deductions to use for certain expenses not paid by your medical/dental/vision plans. Common eligible medical expenses include: medical expense that go towards your deductible, prescription drugs, vision services *–not cosmetic in nature,* and dental services *–not cosmetic in nature.*

You can contribute up to $2,750 to a HCFSA in 2021.

Option 2: Limited Health Care Flexible Spending Account (limited-purpose FSA) – *if you are contributing to a HSA account*

A limited-purpose FSA is much like option 1, in that money is set aside from your paycheck before taxes are deducted. You can then use your pre-tax FSA dollars to pay for eligible expenses. However, under a limited-purpose FSA, eligible expenses are limited to qualifying **dental and vision** expenses for you, your spouse, and your eligible dependents.

*Note: IRS rules do not allow you to contribute to a health savings account (HSA) if you are covered by any non-qualifying health plan, including a general-purpose health FSA. By limiting FSA reimbursements to dental and vision care expenses, you (or your spouse) remain eligible to participate in both a limited-purpose FSA and an HSA. Participating in both plans allows you to maximize your savings and tax benefits. You can contribute up to $**2,750** to a limited-purpose FSA in 2021.*

Dependent Care Flexible Spending Account (DCFSA)

The use of a Dependent Care Flexible Spending account (DCFSA) can help offset expenses you may incur for the cost of daycare for your dependents, day camp in lieu of day care, before/after school care, or adult day care. The DCFSA limit is $5,000 ($2,500 each for married individuals filing separate tax returns) in 2021. Your daycare provider must provide you with a tax identification number or Social Security number for reimbursements under this account.

Accessing your Flexible Spending Accounts

If you enroll in a HCFSA and/or DCFSA, Discovery Benefits will mail a debit card to your home address. It may be used to pay for eligible expenses. If you have both HCFSA and DCFSA, the same debit card may be used to access both accounts. **Hold on to your receipts as you may need them to substantiate your debit payments.**

Rollover Period

If you have HCFSA or DCFSA funds left over on December 31, 2021 you may roll over up to $500 into the next plan year. All claims for reimbursement must be received by Discovery Benefits by March 31, 2022.

Employee Assistance Program (EAP)

Aurora Health Care®

The Aurora EAP is a comprehensive resource that can help you with home, personal, family or work issues. It is confidential and available to you and your family members residing in the household. There is no cost to you for this service.

Services are available for a wide range of personal matters such as:

- Self-improvement
- Dependent care
- Gambling
- Finances
- Parenting/family and marital/relationship
- Legal
- Workplace issues
- Health & wellness
- Alcohol/drug abuse
- Mental health (i.e., depression, stress, anxiety)

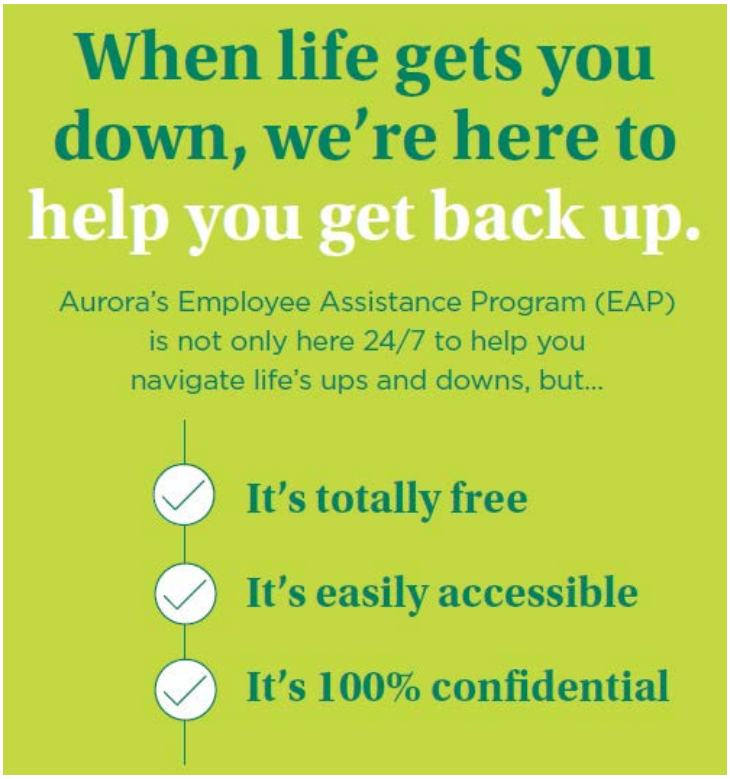
How do I access Aurora EAP services?

To contact Aurora EAP simply call the following phone number to speak with a consultant:

1-800-236-3231

Website: www.aurora.org/eap

Many issues can be addressed directly with your EAP professional. In some cases, you may be referred to other resources and you will be notified of any fees at the time of the referral.



Supplemental Life and Disability

Supplemental and Dependent Life Insurance

Supplemental Life:

Basic Life: Only 1.0 FTE employee are eligible for the $15,000 of term life provided by Washington County.

0.5 – 1.0 FTE employees can purchase Supplemental Term Life Insurance coverage from **$10,000 to $500,000** in $10,000 increments, up to 5 times your earnings. You can get up to $150,000 with no health questions.

Cost: Amount of Coverage ÷ $10,000 = $___ X $___ (rate from the age table) = Total Monthly Cost

Age	Cost*	Age	Cost*	Age	Cost*
15-24	$0.33	40-44	$1.25	60-64	$4.80
25-29	$0.39	45-49	$1.92	65-69	$7.00
30-34	$0.54	50-54	$2.82	70-74	$13.50
35-39	$0.82	55-59	$3.80	85+	$41.50
*This is the monthly cost is per $10,000 of coverage.					

Dependent Spouse/Child Basic Life Insurance:

0.5 – 1.0 FTE employees can purchase Dependent Life for $.65 per month with no health questions during this enrollment. UNUM will provide **$10,000** in Spouse Life Insurance and **$5,000** in Child Life Insurance. This is a bundled policy regardless if you have a spouse or any number of children.

Disability Benefits *Excludes Deputy Sheriff and Elected Officials

Short-term Disability

All 0.5 – 1.0 FTE employees are eligible for Short-term Disability (STD). STD provides you 66.67% of your income while you are out on an approved STD benefit. There is an 8 day elimination period (and if applicable, STD would begin after your Extended Leave Bank is exhausted). Washington County pays 100% of the cost for this benefit.

Long-term Disability

Only 1.0 FTE employees are eligible for Long Term Disability (LTD) benefits. You are automatically enrolled in the Long-term Disability (LTD) plan the first of the month following completion of 30 days. LTD provides you with income at 66.67% up to a maximum of $833 per month, with incremental monthly payments if you are totally and permanently disabled. You can continue receiving LTD benefits until age 65, or until your doctor no longer certifies you disabled. Washington County pays 100% of the cost for this benefit.

Long-term Disability Buy-up

1.0 FTE Employees have the option to purchase the additional benefit. LTD Buy-up provides you with income at 66.67% up to a maximum of $6,112 per month, with incremental monthly payments if you are totally and permanently disabled.

Cost: Your Salary /12 = _____ X 0.231 ÷ 100 = _____ = Your Monthly Premium.

Legal Notices

Health Information Privacy Rights

Your health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive your health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct and find out who has seen it.

Get a copy of your information
You can ask to see or receive a copy of your medical records and other health information. If you want a copy, you may have to put your request in writing and pay for the cost of copying and mailing. In most cases, copies must be given to you within 30 days.

Verify your information is correct
You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result is correct, you still have the right to have your disagreement noted in your file. In most cases, the file should be updated within 60 days.

Find out who has seen your information
By law, your health information can be used and shared for specific reasons not directly related to your care, such as making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information.

Learn how your health information is used and shared by your doctor or health insurer
Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer or share it for things like marketing and advertising without your written authorization. You probably received a notice telling you how your health information may be used when you first visited a new health care provider or when you got new health insurance, but you can ask for another copy at any time.

Limit what information can be shared
Let your providers or health insurance companies know if there is information you do not want to share. You can ask that your health information not be shared with certain people, groups or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can also ask your health care provider or pharmacy not to tell your health insurance company about care you receive or drugs you take if you pay for the care or drugs in full and if the provider or pharmacy does not need to get paid by your insurance company.

Additionally, you can ask to be reached somewhere other than home. You can make reasonable requests to be contacted at different places or in a different way. For example, you can ask to have a nurse call you at your office instead of your home or to send mail to you in an envelope instead of on a postcard.

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, your health insurer or the U.S. Department of Health and Human Services. To learn more, visit www.hhs.gov/ocr/privacy.

Source: U.S. Department of Health and Human Services

Legal Notices continued…

Annual Notice of Women's Health Rights

On October 21, 1998 the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you with this notice outlining the coverage that this law requires our plan to provide. Our group health plan has always provided coverage for medically-necessary mastectomies. This coverage includes procedures to reconstruct the breast, on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance and any complications that could result from the surgery. The following benefits must be provided if benefits are provided for a mastectomy:

- Coverage for reconstruction of the breast on which the mastectomy is performed.
- Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
- Coverage for the prostheses and physical complications resulting from any stage of the mastectomy, including lymphedemas. These benefits are subject to the same deductible, copays and coinsurance that apply to mastectomy benefits under the plan

Newborns' Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Prescription Drug Creditable coverage – Medicare Part D

Washington County provides a "Notice of Prescription Drug Creditable Coverage" to all participants. This notice states that under the medical plan, you have prescription drug coverage that is, on average, as generous as the standard Medicare Prescription Drug Coverage.

Special Enrollment Rights

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Legal Notices continued…

Health Insurance Marketplace Coverage and your options

The Health Insurance Marketplace provides you with a new way to purchase health coverage. To assist you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment based health coverage offered by your employer.

- **What is the Health Insurance Marketplace?** The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "on-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October of each year for coverage starting as early as January 1 of the following year.

- **Can I save money on my health insurance premiums in the Marketplace?** You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

- **Does employer health coverage affect eligibility for premium savings through the Marketplace?** Yes, if you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

- **Note: if you purchase a health plan through the Marketplace instead of accepting health coverage through your employer, then you may lose your employers' contribution. Also, this employer contribution as well as your employee contribution to employer offered coverage is often excluded from income from Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.**

- **How can I get more information?** For more information about your coverage offered through your employer, contact the Human Resource/Benefits Department. The Marketplace can help you evaluate your coverage options including your eligibility for coverage through the Marketplace and its cost. Please visit Healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Individual Coverage Mandate

Effective January 1, 2014, federal law requires that you have Health Care coverage or you may be subject to an income tax penalty. You can enroll in the health plan, or you may want to consider visiting www.healthcare.gov for information on health plans available through the Healthcare Marketplace in your area.

Legal Notices continued…

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the eligible states, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Center for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

REMINDERS

Enroll using Munis/Employee Self Service (ESS) by the 10th of the month before your benefit effective date.

Elections made during your initial enrollment will be effective the 1st of the month following 30 days of employment.

Contact Human Resources with any initial enrollment questions: 262-335-4633.

ESS Website:
https://mywc.washcowisco.gov/ess

Benefit App:
https://washingtoncounty.mybenefitsapp.com/

Packet:
https://packet.co.washington.wi.us/

DISCOVER.
CONNECT.
PROSPER.